Anthem HealthKeepers, Inc.
Commonwealth Coordinated Care Plus
Medicaid Managed Care Program

Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations

With Independent Accountant's Report Thereon

For the period of July 1, 2020 through June 30, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Independent Accountant's Report

Virginia Department of Medical Assistance Services
Richmond, Virginia

We have examined the accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations of Anthem HealthKeepers, Inc. (Anthem) related to the Commonwealth Coordinated Care Plus Program (CCC Plus) for the period of July 1, 2020 through June 30, 2021. Anthem's management is responsible for presenting the Medical Loss Ratio and Underwriting Gain Rebate Calculations in accordance with the criteria set forth in the CCC Plus contract and Centers for Medicare & Medicaid Services (CMS) federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations are in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations were prepared for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the above referenced accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations are presented in accordance with the above referenced criteria, in all material respects, for the period of July 1, 2020 through June 30, 2021. Related to non-expansion, the Adjusted Medical Loss Ratio (MLR) Percentage Achieved does not exceed the minimum requirement of eighty-five percent (85%) and the Adjusted Underwriting Gain Percentage Achieved exceeds the maximum requirement of three percent (3%). In accordance with contractual obligations, MLR and Underwriting Gain remittance amounts are due to the Department of Medical Assistance Services. Related to expansion, the Adjusted MLR Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Underwriting Gain is not applicable per contractual requirements.

This report is intended solely for the information and use of the Virginia Department of Medical Assistance Services and Anthem and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC
Glen Allen, Virginia
August 22, 2023

Adjusted Medical Loss Ratio for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$1,297,417,821	$(3,427,356)	$1,293,990,465
1.2	Improving health care quality expenses	$39,595,464	$(1,123,458)	$38,472,006
1.3	**Total Adjusted MLR Numerator**	**$1,337,013,285**	**$(4,550,814)**	**$1,332,462,471**
Medical Loss Ratio Denominator				
2.1	Revenue	$1,655,092,305	$17,861,063	$1,672,953,368
2.2	Federal and State taxes and licensing or regulatory fees	$80,641,468	$6,016,173	$86,657,641
2.3	**Total Adjusted MLR Denominator**	**$1,574,450,837**	**$11,844,890**	**$1,586,295,727**
Credibility Adjustment				
3.1	Member Months to determine credibility	749,738	0	749,738
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	84.9%		84.0%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**84.9%**		**84.0%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	N		N
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	84.9%		84.0%
5.4	MLR denominator	$1,574,450,837		$1,586,295,727
5.5	**Remittance amount due to State for Coverage Year**	**$1,574,451**		**$15,862,957**

Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$225,425,683	$43,948,275	$269,363,958
1.2	Improving health care quality expenses	$8,336,473	$0	$8,336,473
1.3	**Total Adjusted MLR Numerator**	**$233,762,156**	**$43,948,275**	**$277,700,431**
Medical Loss Ratio Denominator				
2.1	Revenue	$293,273,801	$6,500,513	$299,774,314
2.2	Federal and State taxes and licensing or regulatory fees	$16,380,029	$(10,267,494)	$6,112,535
2.3	**Total Adjusted MLR Denominator**	**$276,893,772**	**$16,768,007**	**$293,661,779**
Credibility Adjustment				
3.1	Member Months to determine credibility	149,428	(8,810)	140,618
3.2	Credibility adjustment	1.7%		1.8%
MLR Calculation				
4.1	Unadjusted MLR	84.4%		94.6%
4.2	Credibility adjustment	1.7%		1.8%
4.3	**Adjusted MLR**	**86.1%**		**96.4%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	Y		Y
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	86.1%		96.4%
5.4	MLR denominator	$276,893,772		$293,661,779
5.5	**Remittance amount due to State for Coverage Year**	**N/A**		**N/A**

Adjusted Underwriting Gain for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Denominator				
1.1	Revenue	$1,655,092,305	$7,995,028	$1,663,087,333
1.2	Federal and State taxes and licensing or regulatory fees	$80,641,468	$13,536	$80,655,004
1.3	**Total Adjusted Underwriting Gain Denominator**	**$1,574,450,837**	**$8,008,564**	**$1,582,432,329**
Medical Expenses				
2.1	Claims	$1,297,417,821	$(3,427,356)	$1,293,990,465
2.2	Improving health care quality expenses	$39,595,464	$(1,123,458)	$38,472,006
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$1,337,013,285**	**$(4,550,814)**	**$1,332,462,471**
Non-Claims Costs				
3.1	Administrative Expenses	$49,174,865	$3,081,087	$52,255,952
3.2	Less: Unallowable Expenses	$(2,988,690)	$(2,605,629)	$(5,594,319)
3.3	**Allowable Administrative Expenses**	**$46,186,175**	**$475,458**	**$46,661,633**
Underwriting Gain				
4.1	Underwriting Gain $	$191,251,377		$203,308,225
4.1	Less: Remittance Amount Due to State for Coverage Year	$(1,574,451)		$(15,862,957)
4.2	Adjusted Underwriting Gain $	$189,676,926		$187,445,268
4.3	**Underwriting Gain %**	**12.0%**		**11.8%**
Underwriting Gain Remittance Calculation				
5.1	Member Month Requirement Met?	Y		Y
5.2	At least 12 months contract experience at the beginning of the Contract Year?	Y		Y
5.3	Percent to Remit	5.5%		5.3%
5.4	**Amount to Remit**	**$87,337,622**		**$84,587,166**

Schedule of Adjustments and Comments for the Period Ending June 30, 2021

During our examination we noted certain matters involving costs, that in our determination did not meet the definitions of allowable medical expenses and other operational matters that are presented for your consideration.

Non-Expansion Adjustment #1 – To adjust claims expense to agree to supporting documentation.

The health plan reported medical expenses based on the trial balance. However, during the examination, the health plan provided documentation to support the most recent data available for the expenses, which included a reconciliation to adjust restated amounts into the period under review. The expenses were adjusted per the health plan support. The clinical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$1,016,910

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$1,016,910

Non-Expansion Adjustment #2 – To adjust directed payments included in revenues and claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(21,861)
2.1	Revenue	$(21,861)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$(21,861)
2.1	Claims	$(21,861)

Non-Expansion Adjustment #3 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, HIF payments, Rx reinsurance payments, maternity kick payments, clinical efficacy payments, discrete incentive payments, and performance withhold payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	$17,882,924

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$17,882,924

Non-Expansion Adjustment #4 – To remove Health Insurer Fee (HIF) expense and the revenue included in the Underwriting Gain calculation.

The health plan has included HIF expense in taxes and licensing or regulatory fees and HIF revenue was included in the Underwriting Gain calculation through Non-Expansion Adjustment #3. HIF revenue includes a gross up amount to reimburse the health plan for the tax impact of HIF. HIF expense and revenue has been removed from the Underwriting Gain per the CCC Plus MCO Contract, Section 19.8.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$(9,866,035)
1.2	Federal and State taxes and licensing or regulatory fees	$(6,002,637)

Non-Expansion Adjustment #5 – To adjust to include incurred claims related to the dental vendor, DentaQuest.

The health plan reported contractual cost plus expenses for dental services arranged by DentaQuest. During the examination, it was determined that this expense was greater than the actual claims incurred and paid by DentaQuest. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(763,870)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$(763,870)
3.1	Administrative Expenses	$763,870

Non-Expansion Adjustment #6 – To adjust vision expenses to actual costs incurred.

The health plan reported a per-member-per-month (PMPM) capitation expense for vision services arranged by EyeMed Vision Care, LLC (EyeMed). During the examination, it was determined that this capitation expense was greater than the actual claims incurred and paid by EyeMed. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(243,407)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$(243,407)
3.1	Administrative Expenses	$243,407

Non-Expansion Adjustment #7 – To adjust transportation expenses related to Southeastrans and Access2Care to actual costs incurred.

The health plan reported contractual cost plus expenses for transportation services arranged by Southeastrans and Access2Care. During the examination, it was determined that the combined transportation expense was greater than the actual claims incurred and paid by Southeastrans and Access2Care. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(711,539)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$(711,539)
3.1	Administrative Expenses	$711,539

Non-Expansion Adjustment #8 – To adjust to remove non-allowable Healthcare Quality Improvement (HCQI) expenses.

The health plan reported Healthcare Quality Improvement Expenses (HCQI) based on an analysis of cost centers that they determined to be HCQI. During the examination, it was noted that several of the cost centers included in HCQI had non-qualifying expenses that did not meet the definitions of HCQI for MLR reporting purposes. Amounts were found at the cost center level, account level, and within the salaries review of job descriptions. The proposed adjustment is to remove non-qualifying HCQI expenses from the MLR calculation and to reclassify these expenses to non-claims administrative expenses within the underwriting gain calculation. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Improving Health Care Quality Expenses	$(1,123,458)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Improving Health Care Quality Expenses	$(1,123,458)
3.1	Administrative Expenses	$1,123,458

Non-Expansion Adjustment #9 - To adjust to reclassify claims payments made to Public Partnerships LLC (PPL), the consumer directed services vendor, in excess of vendor payroll from claims expense to administrative expense.

The health plan reported claims expense for consumer directed services arranged by PPL. During the examination, it was determined that the reported claims expense was more than the sum of gross pay and employer taxes incurred and paid by PPL. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation. The excess has been added to administrative costs and removed from claims expense.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(3,612,718)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$(3,612,718)
3.1	Administrative Expenses	$3,612,718

Non-Expansion Adjustment #10 – To adjust administrative expenses to remove start-up costs and include amortization expense related to start-up costs, per the 2020 and 2021 administrative cost procedures.

Adjustments are applied to administrative costs through a separate engagement. Start-up costs related to Medicaid Enterprise Systems and Provider Services Solution were included in administrative expenses which were removed and the related amortization expense was added. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.477 and CMS Pub. 15-1: §2132 – Start-Up Costs.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expenses	$(185,219)

Non-Expansion Adjustment #11 – To adjust to agree to the MCO's self-exclusion related to state and federal taxes to pro-rated amounts per the administrative cost procedures.

Procedures are applied to administrative costs through a separate engagement. The health plan self-excluded income tax expense however the exclusion was understated in comparison to the amounts confirmed through the administrative cost procedures engagement. We have made an adjustment to agree to pro-rated exclusions verified through this separate engagement. The administrative cost principles are addressed in 45 CFR § 75.400 through 75.477.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expenses	$(2,296,346)

Non-Expansion Adjustment #12 – To adjust to remove fraud reduction expense, which was duplicated in claims and administrative expenses.

The health plan duplicated fraud reduction expense within reported claims expenses and administrative expenses. We have made an adjustment to remove the duplicated administrative expense. The administrative reporting requirements are addressed in 45 CFR § 75.400 through 75.477.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expenses	$(124,064)

Non-Expansion Adjustment #13 – To adjust income tax expense to verified amounts

The health plan calculated the state and federal taxes utilizing effective tax rates for 2020 and 2021 and applying them to an underwriting gain calculation. The adjusted tax expense was calculated using the adjusted revenues and expense and using a combined tax rate applicable to the period. The tax reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 § 438.8(f)(3) and 45 § CFR 158.162.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	$6,016,173

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.2	Federal and State taxes and licensing or regulatory fees	$6,016,173

Non-Expansion Adjustment #14 – To adjust claims Incurred but Not Reported (IBNR) at the time of the MLR filing to IBNR as of March 2023.

The reported IBNR was adjusted to agree to the March 2023 lag table. We have made an adjustment for the difference of $1,402,579 to Medical Loss Ratio line 1.1 and Underwriting Gain Line 2.1. The IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(1,402,579)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$(1,402,579)

Non-Expansion Adjustment #15 - To adjust to reclassify reinsurance recoveries from claims expense to administrative expense.

The Medicaid Managed Care Final Rule provides that the net payments or receipts related to risk sharing mechanisms, such as reinsurance, may be includable within the Denominator of the MLR calculation when this risk sharing mechanism is described within the health plan's contract with the state. When this is not described within the contract, these net reinsurance amounts, by default, should be classified as non-claims costs and excluded from the MLR calculation. Reinsurance expenses are not described within the health plan's contract with the Virginia Department of Medical Assistance Services. These expenses and recoveries are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.6(b), 438.8(b), and 438.8(f)(2)(vi).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$3,373,906

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$3,373,906
3.1	Administrative Expenses	$(3,373,906)

Non-Expansion Adjustment #16 – To adjust pharmacy expenses related to IngenioRx and CVS Caremark to actual costs incurred.

The health plan reported claims expense net of rebates and amounts received from pharmacies for pharmacy services arranged by IngenioRx and CVS Caremark. During the examination, it was determined that rebates and amounts received from pharmacies related to rate guarantees and transmission fees, as a reduction to claims payments, were understated in comparison to the amount reported by IngenioRx and CVS Caremark. It was also determined that amounts received by CVS Caremark from pharmacies related to rate guarantees and transmission fees, as a reduction to claims payments, were not reported. Expense was adjusted to agree rebates to supporting documentation provided by CVS Caremark and offset amounts received by pharmacies.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees".

Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), CMCS Informational Bulletin: Medicaid Prescription Spread Pricing 05/15/2019, and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$(1,062,197)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$(1,062,197)

Expansion Adjustment #1 – To adjust revenues and claims to include related directed payments.

The MLR Report did not reflect directed payments in the numerator nor the denominator of the calculation. It was determined the Managed Care contracts refer to 42 CFR § 438.6(c) in speaking to directed payments related to private acute care hospitals, nursing facilities, Chesapeake Regional Medical Center, and State University teaching hospital physicians; and therefore should be included in the MLR calculation. Premium revenue and incurred claims were adjusted to include the payments and associated expense per state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$43,938,275
2.1	Revenue	$43,938,275

Expansion Adjustment #2 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, HIF payments, maternity kick payments, clinical efficacy payments, performance withhold payments, and risk corridor recoupments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	$(37,437,762)

Expansion Adjustment #3 – To adjust member months to agree with state data.

The health plan reported member months that did not reflect accurate member months for the reporting period. Member months were adjusted per the state's data. Member months impact the credibility adjustment applied to the MLR. The general reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
3.1	Member Months to determine credibility	(8,810)

Expansion Adjustment #4 – To adjust income tax to verified amounts.

The health plan calculated the state and federal taxes utilizing effective tax rates for 2020 and 2021 and applying them to an underwriting gain calculation. The adjusted tax expense was calculated using the adjusted revenues and expense and using a combined tax rate applicable to the period. The tax reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 § 438.8(f)(3) and 45 § CFR 158.162).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	$(10,267,494)